SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

Michigan Department of Community Health

1. CONTROL NUMBER

NOTE: APPROVAL REFERS TO SERVICE AND DOES NOT GUARANTEE RECIPIENT ELIGIBILITY.

CONSULTANT USE ONLY

2. 3. 4. 5. 6. 7. 8. 9. 10.

11. PRIOR AUTHORIZATION NO.

12. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIATL)	13. TYPE	14. ID NUMBER	15. PROVIDER USE ONLY
16. PROVIDER'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)			17. PHONE NUMBER
18. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIATL)	19. SEX	20. ID NUMBER	21. BIRTH DATE / 22. COUNTY
23. RECIPIENT'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)			24. DOES PATIENT RESIDE IN A NURSING CARE FACILITY? ☐ YES ☐ NO
25. REFERRING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	26. TYPE	27. ID NUMBER	28. PHONE NUMBER
29. REFERRING PHYSICIAN'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)			

30. LINE NO.	31. DESCRIPTION OF SERVICE (INCLUDE BRAND NAME AND MODEL NUMBER WHERE APPLICABLE)	32. PROCEDURE CODE	33. QUANTITY	34. CHARGE	35. MODIFIER
01					
02					
03					
04					
05					

36. PRIMARY DIAGNOSIS DESCRIPTION AND PRESCRIPTION (QUOTE PHYSICIAN ORDER)	37. REMARKS AND/ OR DOCUMENTATION OF MEDICAL NECESSITY

38. INDICATE ANY OTHER SERVICES PROVIDED TO THIS RECIPIENT DURING THE PAST YEAR

39. PROVIDER CERTIFICATION: The patient named above (parent if minor or authorized representative) understands the necessity to request prior approval for the services indicated in item 31. I understand the services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State law.

PROVIDER SIGNATURE _____ DATE _____

CONSULTANT USE ONLY

40.	41.	42.
APPROVED AS:	DISAPPROVED ☐	
PRESENTED ☐	NO ACTION ☐	
AMENDED ☐	INSUFF. DATA ☐	CONSULTANT SIGNATURE _____ DATE _____

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

MSA-1653-B (04-03) PREVIOUS EDITION MAY BE USED

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

Prior Approval Request/Authorization Form Completion Instructions

The Special Services Prior Approval-Request/Authorization (MSA-1653B) is utilized by Medical Suppliers, DME Providers, Orthotists, Prosthetists, Hearing Aid Dealers and Hearing and Speech Centers. The form is generally self-explanatory. . Completion of boxes 12 through 39 is mandatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, please refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters.
- Billing & Reimbursement for Professionals Chapter of this manual.
- Provider-specific Databases on the MDCH website.

Box 1-11	MDCH Use Only
Box 24	Check Yes if beneficiary is in NF or No if the beneficiary is not in an NF. Provide NF Address and Phone Number in Box 37
Box 31	Enter a complete description of the item, including manufacturer, model, style, etc. requested..
Box 32	Enter the HCPCS Procedure Code
Box 35	Enter the applicable HCPCS Modifier
Box 36	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). Provider Types 85 and 87 must submit the prescription/CMN with this form.
Box 37	Any additional remarks regarding the request should be listed in this box such as NF Name, Address, and Phone Number, verbal authorization date, retroactive date of service if being requested, etc.

See the Directory Appendix for form submission contact information.